CMS-1429-P-800

Submitter : Linda Bergen **Date & Time:** 09/05/2004 07:09:22

Organization : Member of National Athletic Trainer's Association

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See attached Word document.

CMS-1429-P-800-Attach-1.doc

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: The attachment cited in this document is not included for one of the following reasons:

1. Improper format.
2. The submitter did not follow through when attaching the document.
3. The submitter had intended to attach more than one, but not all attachments were received.
4. The type of document provided was a password-protected file. CMS was given read-only access to the document.

We cannot provide this electronic attachment to you at this time, but you would like to view any of those that are not posted on this web site, you may call CMS and schedule an appointment at **1-800-743-3951**. Those comments along with its attachment(s), that could not be posted, will be available for your viewing at that time.

Submitter : Ms. Cynthia Michaud **Date & Time:** 09/05/2004 07:09:36

Organization : National Athletic Trainers Assoc.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached

CMS-1429-P-801-Attach-1.doc

CMS-1429-P-802

Submitter : Ms. Pamela Wright **Date & Time:** 09/05/2004 08:09:18

Organization : King's College

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a current junior at King's College majoring in the Athletic Training program. I am writing to express my concern over the recent proposal that would limit providers of 'incident to' services in physician offices and clinics. If this proposal was to pass it would eliminate the ability of qualified health care professionals, in which I hope to become, to provide these very important services. When entering this major I knew of what I could and could not do if I were in fact to become an Athletic Trainer. Everything I have learned throughtout these years so far has prepared me for exactly that. However this proposal might take that away and this deeply upsets me. Everything I have learned will have to be changed. This is not fair. I have worked very hard in my major the last two and a half years to have this taken away. My professors here at King's College also have worked very hard to get where they are today. I do not agree with this proposal and think that if the Athletic Trainers' right to provide 'incident to' services were taken away and they had to work under a qualified personnel, things would NOT work as efficiently as they do today. It would reduce the quality of health care and increase the costs of these services. In conclusion it would not be an advantage of the CMS to go forth with this proposal for the reasons indicated above.

Sincerely,
Pamela Wright

CMS-1429-P-803

Submitter : Dr. Dana O'Brien **Date & Time:** 09/05/2004 08:09:57

Organization : Dr. Dana O'Brien

Category : Individual

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support the proposed rule changes.

CMS-1429-P-804

Submitter : Dr. michael ziegelbaum **Date & Time:** 09/05/2004 10:09:09

Organization : lake success urology associates

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

I would like to take this opportunity to protest the implementation of the revised payment policies under the physician fee schedule for 2005. I am seriously concerned that implementation of these reductions will be the straw to break the backs of many medical practices. As a urologist my fees have been reducing over the last decade for surgical work that I do. The margin between staying solvent and closing the doors to my patients is quite thin.

The average sales price solution to physician administered drug reimbursement is simply unfair. There is no accounting for the administration, storage and cost outlay of these medications. My purchase price has no relationship to what will be calculated as an average sales price. Indeed the cost of many drugs are already higher than Medicare allowable fees.

Furthurmore, the method at arriving at the average sales price has yet to be determined. At best it will be a rolling number. If that occurs there is no way for my office to calculate fees fairly and in a timely fashion. By regulating my fees without regulating those of the drug suppliers, I am being asked to run a business without any consideration for our ability to remain solvent.

If these rules are enacted, I will have few choices. Weak and debilitated cancer patients will have to go to a retail drug store and bring the medications to me for administration or they will be sent to hospital settings. Either solution will result in greater total expense and higher patient outlys and copays. I suspect many will give up out of frustration and forego adequate oncologic care.I also know that many physicians will be forced outof practice thus increasing the burden of patient care manifold in clinics, emergency rooms and hospitals.

I appreciate your consideration of my comments. I do hope that CMS and Congress see fit to overturn these rulings. I am certain that CMS-1429-P is yet one more ruling that may accelerate inadequate and poor care for our Medicare recipients.

Submitter : Mr. Joseph Salazar **Date & Time:** 09/05/2004 11:09:42

Organization : National Athletic Training Association

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Joseph M. Salazar,
1112 Brittany Pl>
Ft. Wayne, IN 46825>

9-5-04

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient. There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.
In many cases, the change to ?incident to? services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.
This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working ?incident to? the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.
Patients who would now be referred outside of the physician?s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient?s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.
Curtailing to whom the physician can delegate ?incident to? procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician?s ability to provide the best possible patient care.
To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide ?incident to? services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners

may provide ?incident to? care in physicians? offices would improperly remove the states? right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
CMS, in proposing

Sincerely,
Joseph M. Salazar, MEd, ATC, LAT

CMS-1429-P-806

Submitter : Dr. John Conant **Date & Time:** 09/05/2004 11:09:14

Organization : Conant Urology, LLC

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

John K. Conant, Jr., M.D.
60 Westwood Avenue
Waterbury, CT 06708-2460

September 5, 2004

Dear Dr. McClellan,

The scheduled 2005 drug payment changes may be the straw that breaks the camels back. I recently compared what Medicare paid for my six most common surgical procedures in 1991 and compared the amount to what they paid in 2002. The actual dollar decrease, NOT taking inflation in to account, ranged from 10-70%. This has forced me to see twice as many patients as I did 12 years ago. It is hard to see so many people and do it well. I am working much harder for much less. I am paying my bills and that is about it. What is more, I don't have much of a life outside of work because I must stay late everynight to do the paper work I used to do during the day when I had a chance. Every free moment during the day and sometimes more is used to see patients so my my free time and my continuing education suffer badly. I think that I ought to be making a reasonable sum for what I do. Why is it that an attorney can charge thousand of dollars for a retainer just for their presumed expertise. I think my expertise has much greater value than that of an attorney and it certainly involve a lot more personal sacrifice to acheive. If the payment for drugs is reduced again I may not be able to stay in business. I have cut everywhere I could and live on less. I am not sure why I should pick up the tab for the health care of others beyond what I pay in taxes.

As it stands now it costs me to provide medications like BCG for my patients. The problem will get worse because I am a solo practitioner so I cannot negotiate or take advantage of voulme discounts. For the amount of money that I tie up to supply my patients with Lupron it will hardly be worth it to supply it for them. It will be inconvenient for a few and impossible for most patients to get it themselves if I give them a prescription for Lupron. If I am forced to supply it I will probably have to send the patient to another Urologist because I just cannot afford the loss I would take on each dose.

I am puzzled by the governments response to the "healthcare crisis" we are experiencing. If health care is so important and if the goal is to make it available to everyone then why are the people who provide it punished with lower reimbursents, more legislative hassles, and more fees? You are more likely to drive me to change professions than to take on patients who cannot afford to pay. I have already had to drop Medicaid because I cannot afford what it costs me to take care of those patients. You of all people should realize that healthcare starts with doctors and if there are no doctors there is no healthcare. Why should be treated differently from others in this free country. Urologists are in short supply now but what we are paid continues to go down. It is frustrating, demoralizing and just plain unjust to abuse physicians economically when we have no legal way to fight back.

Yours truly,

John K. Conant, Jr., M.D.

Submitter : Linda Bergen **Date & Time:** 09/06/2004 12:09:17

Organization : Linda Bergen

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

CMS-1429-P-807-Attach-1.doc

CMS-1429-P-808

Submitter : Dr. Alex Sneiders **Date & Time:** 09/06/2004 12:09:21

Organization : Valley Urology Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

Dear Dr. McClellan:
I am a urologist in solo practice in Renton, Washington. The recently published fee schedule creates a great deal of angst in terms of strategic planning, staffing and patient access.
? The August 5 proposed rule lists estimated 2005 payments for only three urology drugs. Although these drugs represent 94 percent of 2003 drug payments for urology, there are still important drugs for which we have no information. For example, bladder cancer drugs, which in some cases are already reimbursed less than they cost, are not on the list. Also, actual 2005 payments will be based on third quarter 2004 data, which won't be available until after October 30. How can I assess the impact of payment changes on my practice and my patients when I don't even have a complete list of estimated 2005 payments?
I have grave concerns about the impacts the drug payment changes will have on urology patients-particularly cancer patients. According to the proposed rule published on August 5, urologists receive 37 percent of their total Medicare revenue from drugs and their Medicare drug revenue will decrease by 36 percent between 2004 and 2005. Such a short transition time for these massive payment reductions has the potential to greatly disrupt or hinder treatment for urology patients who currently receive drug therapy in the office for prostate cancer, bladder cancer, interstitial cystitis and other urological diseases.
? I will not be able to continue to provide drugs to patients in my office if the payments are lower than my cost of buying and administering the drugs. This is especially true for Medicare patients who do not have Medigap policies. With a 6 percent markup, I can not afford to order, stock and cover the bad debt associated with it for patients that do not have supplemental Medicare coverage. Additionally, in Washington a Business and Occupation tax of approximately 2 percent is applied on all revenues collected, leaving me with less than a 4 percent margin to cover associated expenses. Many of my Medicare patients are poor and will not be able to pay the co-pay up front, meaning that they may choose to forego the proper care.
? As a small business owner, it is difficult to adapt so quickly to such large payment cuts, and I will have to make drastic changes in my practice when payments are based on average sales price (ASP) in 2005. These changes include laying off employees, discontinuing or limiting the types of treatment I am able to offer to Medicare patients, or sending patients to the hospital for drug administration (where they will pay a higher co-pay).
? These cuts are coming on top of cuts that already went into place in January 2004, and I have only had one year to reevaluate and restructure my business plan, budget and patient care plans in light of these drastic payment changes. I can't recall any other major change in the Medicare program that was implemented in such a short time without some sort of transition time built in to mitigate impacts.

As you likely realize, these changes are occurring at a time when medical malpractice insurance rates are climbing rapidly, staffing costs (salaries and medical insurance) are increasing and equipment and supplies are also getting more costly. These combined business pressures will soon come to bear and force a change in not only my practice, but urology practices across the country.

Due to the relatively high percentage of Medicare patients in this area, I am finding it very difficult to recruit a urologist to join me in practice. In the recent past I have had one partner retire early in order to avoid dealing with cuts in reimbursement and a second partner left to practice in an area with a lower percentage of Medicare patients.

Our parents and seniors deserve better than to be left without adequate urological care.

Sincerely yours,

Alex Sneiders, M.D., F.A.C.S.

CMS-1429-P-808-Attach-1.doc

CMS-1429-P-809

Submitter : Dr. Matthew Hasford **Date & Time:** 09/06/2004 03:09:18

Organization : Hi Point Urology Center

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

As a member of the AUA, I am extremely concerned about the proposed cuts in urologists' reimbursements from medicare. It is rather unfortunate that this proposal is being considered at a time when the prices of drugs and supplies used by urologists to cater for their patients are rising. Ultimately it is the patients and medicare itself who will suffer as urologists like myself will either give up these much needed services or transfer them to a hospital setting.

Let me be more specific. Currently I use intravesical agents to treat blader cancer in my office. The patients prefer this appoach because it is much more convenient, efficient and private. Moreover it places less financial stress on our already bruised healthcare system. If this proposal passes, I will have no choice but to result to treating these patients in the hospital, which will be far more costly to medicare. It is mind boggling why people will come up with such an idea.

I am writing to urge medicare to seriously reconsider this proposed rule and have a serious debate about the issue. I believe that in the end it will become evident that this proposition ought to be retracted.

Thanks for paying attention to my point of view.

Submitter : Ms. Carrie Malone **Date & Time:** 09/06/2004 05:09:36

Organization : Arizona School of Health Sciences

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See attached letter, this needs to be reconsidered.

CMS-1429-P-810-Attach-1.doc

CMS-1429-P-811

Submitter : Kenneth Kopke **Date & Time:** 09/06/2004 12:09:29

Organization : Athletic Training Services, Inc.

Category : Academic

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

see attached letter

CMS-1429-P-811-Attach-1.doc

CMS-1429-P-812

Submitter : **Date & Time:** 09/06/2004 01:09:21

Organization :

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a physical therapist currently working in a physician owned physical therapy practice and have experience in the private and hospital based physical therapy clinics. From my experiences, it is clear the best providers of physical therapy are individuals graduating from a physical therapy professional program. A phyisican may be a great doctor, and have extensive skills and knowledge but that does not equate to being even an adequate provider of physical therapy. I have seen numerous patients over the years that have been provided so called physical therapy services without a physical therapist providing the services. These patients consistently recieve the same treatment interventions without any considerations for an individualized rehabilitation program. Such 'cook book' approaches extend the total time to recovery and increase the costs of healthcare as all of these patients I have seen have been seeking second opinions or care from a physician specialist.
Physical therapists are licensed in the states they practice in and all graduating physical therapists attend a post-baccaulaureate physical therapy program. A physical therapist or a physical therapist asistant under the supervision of a physical therapist have the ability to implement a individualized treatment program directed at a patient's functional limitations and primary biomechanical stressors, as opposed to a plan based on a patient's symptoms.
In my opinion allowing only physical therapists to provide physical therapy is in the best interest of the healthcare recipient, results in the greatest patient care, decreases the cost and length of recovery. Additionally, the majority of reputable therapy providers in my community that bill incidient to a physician use physical therapists as their provider of physical therapy services.
A revision of billing therapy incident to physician will force changes only on the less reputable providers, those physicians that have physical therapists as employees and bill incident to a physician would be relatively unchanged.

Thank you for your time and consideration of this issue.

Submitter : Dr. Arthur Schultes **Date & Time:** 09/06/2004 01:09:33

Organization : General Practitioners, P.A.

Category : Physician

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

See attached letter

CMS-1429-P-813-Attach-1.doc

Submitter : Dr. David Lake **Date & Time:** 09/06/2004 01:09:19

Organization : Armstrong Atlantic State University

Category : Physical Therapist

Issue Areas/Comments

Issues 10-19

THERAPY ASSISTANTS IN PRIVATE PRACTICE

KEY POINT: I strongly support CMS?s proposal to replace the requirement that physical therapists provide personal supervision (in the room) of physical therapist assistants in the physical therapist private practice office with a direct supervision requirement. This change will not diminish the quality of physical therapy services.

Other Points (if they apply to your practice):
Physical therapist assistants are recognized under state licensure laws as having the education and training to safely and effectively deliver services without the physical therapist being in the same room as the physical therapist assistant. No state requires personal (in the room) supervision of the physical therapist assistant.

Physical therapist assistants are recognized practitioners under Medicare and are defined in the regulations at 42 CFR ?484.4. According to this provision, a physical therapist assistant is ?a person who is licensed as a physical therapist assistant by the State in which he or she is practicing, if the State licenses such assistants, and has graduated from a 2-year college-level program approved by the American Physical Therapy Association.

Requiring direct supervision would be consistent with the previous Medicare supervision requirement for assistants that physical therapists in independent practice (PTIPs) were required to meet prior to 1999.

Changing the supervision standard from personal (in the room) to direct would protect the privacy of the patient?s that receive services from physical therapists and physical therapist assistants. It will enhance protection to keep private conversations about a patient?s care from being overheard.

This change in supervision standard will not cause physical therapists to change staffing patterns. As licensed health care providers in every jurisdiction in which they practice, physical therapists are fully accountable for the proper delegation and direction of services. The majority of states have physical therapist/physical therapist assistant supervision ratio limits in their state laws or Board rules.

CMS-1429-P-815

Submitter : Mr. Brad Morgan **Date & Time:** 09/06/2004 01:09:59

Organization : Mr. Brad Morgan

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached letter

CMS-1429-P-815-Attach-1.doc

Submitter : Dr. Tim Uhl **Date & Time:** 09/06/2004 02:09:36

Organization : National Athletic Trainers Association

Category : Individual

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September 7, 2004
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To (Section 410.36)

Dear Dorothy Shannon

I am writing to express my concern over the proposal to amend section 410.36 that would limit providers of ?incident to? services in physician offices and clinics. If adopted, this would significantly inhibit the ability of physicians to provide quality and complete health care to their patients.

As a licensed physical therapist and a certified athletic trainer that has worked along side physicians for nearly 20 years in providing care to patients, I have seen the best outcomes when a team of qualified health care providers work together to improve the patients health. I feel that certified athletic trainers have the educational background and clinical skills necessary to provide quality care of patients under physician, physician assistant, nurse practitioner, or clinical nurse specialist direction. By allowing certified athletic trainers to assist in providing these services patients will have more exposure to well trained health care professionals, in this time of limited available resources.

All certified or licensed athletic trainers must have a bachelor?s or master?s degree from an accredited college or university. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT). This educational background is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other health care practitioners.

I believe that the physical medicine CPT codes are intended for use by qualified health care providers and that certified athletic trainers are qualified to provide these services. I urge you to reconsider that the proposed policy change should include not exclude certified athletic trainers.

Sincerely,

Tim L. Uhl PhD ATC PT

CMS-1429-P-816-Attach-1.doc

Submitter : **Date & Time:** 09/06/2004 02:09:40

Organization :

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

September 6, 2004

Department of Human Performance
1400 Highland Center
Mankato, Minnesota 56001

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

As a future Certified Athletic Trainer (ATC) and possible future patient, I feel compelled to write this letter in opposition of proposal CMS-1429-P. I am concerned that this proposal would limit patient access to qualified health care providers of ?incident to? services, such as ATCs, in physician offices and clinics; thereby, reducing the quality of health care for physically active patients. Furthermore, limiting access to qualified health care providers will cause delays in the delivery of health care, which in turn will increase health care costs and tax an already heavily burdened health care system.

Athletic training is the health care profession that specializes in the prevention, assessment, treatment and rehabilitation of injuries to athletes and others who are engaged in everyday physical activities. Athletic trainers are multi-skilled health care professionals who can, and are, making significant contributions to health care. Athletic trainers are highly educated and fully qualified health care providers, evident in their recognition by the American Medical Association as an allied health care profession. If this proposal would pass, it would threaten the employment of many athletic trainers who are employed as physician extenders in clinics and physician offices. Therefore this proposal threatens my future employment in those settings and the value of my degree in Athletic Training. With this type of limitation artificially placed on the provision of ?incident to? services by qualified (through accredited academic programs in athletic training, a national board examination, and state practice acts) health care providers the CMS will only add to the skyrocketing health care costs, put qualified people out of work, and reduce the overall quality of health care in the United States.

In conclusion, I believe that the CMS-1429-P proposal must be rejected in order to protect the rights (the right to choose and the right for quality care) of our patients and my right as a future health care practitioner.

Sincerely,

Sarah Brosch

Athletic Training Student at the College of Charleston, South Carolina

CMS-1429-P-818

Submitter : Ms. Priscilla Hawley **Date & Time:** 09/06/2004 02:09:19

Organization : Stevenson & Associates

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

To: Mark B. McClellan, MD, PhD

From: Priscilla Hawley, PT, APTA member

Subject: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005.

Reference: "Therapy-Incident To" Physician Services

I am writing to you concerning the incidents to the revision under the physician fee schedule calendar year 2005 with the CMS qualifications for physicians providing physical therapy in their offices. As a new graduate of May 2004 working at an outpatient rehab setting, I believe each patient needs to have the same high level of care. In the setting where I am employed, all of the patients are seen by licensed physical therapists or physical therapy assistants. I feel that this is in the patient's best interest and should be uniformly applied in all settings to standardize the level of care. The patient deserves the best level of care available and this care can only be achieved by the education and experience of a licensed physical therapist. I currently graduated after seven years of education and obtained my Doctorate in Physical Therapy from Washington University and passed a national examination prior to being able to treat patients. My training consisted of extensive anatomy, physiology, medical screening, clinical experience, and much more. With this background physical therapist can provide the utmost possible care. Even after graduating, the education does not stop secondary to frequent continuing education courses. I believe that for Medicare to be paying for unqualified services is not in the patient's best interest and is potentially harmful to the public. As a new graduate, I believe that it would truly be in a Medicare patient's best interest that all settings provide the highest quality of care from a licensed physical therapist. Thank you for your time.
Sincerely,
Priscilla Hawley, PT, DPT
Staff Physical Therapist
Stevenson & Associates

Submitter : Gary Minnella **Date & Time:** 09/06/2004 04:09:23

Organization : NATA

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

SEE ATTATCHED FILE

CMS-1429-P-819-Attach-1.doc

CMS-1429-P-820

Submitter : **Date & Time:** 09/06/2004 04:09:56

Organization :

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am a physical therapist with thirty years of experience currently working in a hospital based outpatient department. I am writing to express strong support for CMS's proposed requirement that physical therapists working in physician's offices be graduates of accredited professional physical therapist programs. Physical therapists and physical therapist assistants under the supervision of physical therapists are the only practitioners who have the education and training to furnish physical therapy services. Physical therapists are professionally educated at the college or university level in programs accredited by the Commission on Accreditation of Physical Therapy, an independent agency recognized by the U.S. Department of Education. All programs offer at least a master's degree, and the majority will offer the doctor of physical therapy degree by 2005. Physical therapists are fully accountable for their professional actions and must be licensed in the states where they practice. The background and training that physical therapists have enables them to obtain positive outcomes for individuals with disabilities and other conditions needing rehabilitation. This education and training is particularly important when treating Medicare beneficiaries. Unqualified personnel should not be providing physical therapy services. By allowing lesser educated individuals incident to a physician endangers the patients. I would like to thank the Administrator for this opportunity of expression and his consideration of my comments.

CMS-1429-P-821

Submitter : Ms. Debra Gorman-Badar **Date & Time:** 09/06/2004 04:09:55

Organization : Anaconda Physical Therapy Center

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

For the following reasons, I strongly urge CMS to include the "Incident To" provision in the final rule. First, Physical Therapists and Physical Therapist's Assisstants are the only health care providers that have the education and training to provide rehabilitation physical therapy services. The same is true for Occupational Therapists, Certified Occupational Therapist's Assistants and Speech Therapists in their respective fields of rehabilitation. Individuals with other education and training such as athletic trainers, kinesiotherapists, exercise physiologists, etc. do not have education and training in rehabilitation. Education and training in rehabilitation in physical therapy programs includes a reasoning thought process for evaluation, assessment, development of individualized treatment plans, and problem-solving when patient care is complicated or does not follow standarized protocols.

In my 22 years of being a physical therapist, I have seen many patients who are treated by less qualified caregivers first. After coming to see me, they remark that they are sorry that they didn't come to me first. I think that this is because physical therapist's education and training promotes a holistic approach to patient care with an emphasis on home programs and self-management. Personally, I would only choose to see a physical therapist for physical therapy services. I have the utmost respect for physicians providing medical and surgical services, but I would never go to someone (not a physical therapist) who is supervised by a physician for physical therapy services. Physicians are educated and trained in medicine, not rehabilitation.

Second, in times of limited health care dollars, CMS should require only the highest qualified persons, physical therapists and physical therapist's assistants, to provide physical therapy care for its beneficiaries. This not only insures good care, it eliminates potential harm that can be caused by less qualified persons and/or the waste of health care dollars for treatment that is ineffective, resulting in patients needing to see a physical therapist.

Third, we already know that physicians who hire physical therapists in their office do not give their patients a choice of where they receive physical therapy services. Patients are routinely directed or steered to the physician's physical therapy department. Over the years I have had numerous patients relate to me that they felt that they HAD to go to the physician's physical therapy department. One patient was even required to travel 100 miles each way 3 days a week when he could have come to see me 1 mile away. This unethical situation of taking away a patient's choice to receive physical therapy services where they would prefer to go or where it is most convenient for them would only worsen. With removal of the "Incident To" requirement for a licensed physical therapist to provide physical therapy services, I think we would see an influx of less qualified caregivers into physician owned physical therapy departments and patients would not even have a choice of seeing a physical therapist for their physical therapy/rehabilitative care. As a person with parents who are Medicare beneficiaries I must be strongly opposed to this. In ethics the human analogy is, "It is harmful to cause what is irrational to want." Would any of you, as a patient, want to be in this position - being sent to an unqualified caregiver with no choice to go where you know that you can receive better care? With the current rule, you would know that you are being required to see a physical therapist. Even if your choice of which physical therapist to see is usurped, your choice to see a physical therapist who is most qualified to provide physical therapy services is not taken away from you.

Thank you for your time and consideration,

Debra Gorman-Badar, PT, MA

Submitter : Ms. Shelly Young **Date & Time:** 09/06/2004 05:09:31

Organization : Sutter Maternity and Surgery Center

Category : Hospital

Issue Areas/Comments

GENERAL

GENERAL

Shelly Young
Sutter Maternity and Surgery Center
2900 Chanticleer Ave.
Santa Cruz, CA 95065

September 2004

Center for Medicare & Medicaid Services
Department of Health & Human Services
Attention CMS 1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

CMS Code 1429-P

I am writing to comment on the Proposed Rules governing the Physician Fee Schedule for Calendar Year 2005 as printed in the Federal Register of August 5, 2004.

Please reconsider your proposed rule. CMS committed in 1996 to update the physician payment localities if there has been a significant change in practice costs. Santa Cruz County remains the most disadvantaged county in California. The payment differential for physician services in a county less than 20 miles from our business is over 25% greater than for services performed by local physicians. We understand that this is by far the greatest differential in the country.

This needs to stop. We are losing doctors and important specialties. Our organization cannot fathom how this is allowed to continue. We believe that Congress has delegated to CMS the responsibility to manage the payment to physicians. Further, we believe that no other county in the U.S. is in greater need of reform than our county. It is your responsibility to correct this problem. Continued postponement of this long-needed reform is ill advised and inappropriate.

Health care costs are high in our community. The economy of this county is entirely equivalent to Santa Clara County. Housing costs, wages, and benefits are equivalent. How can you support the payment differential as you propose in your rule? How can you continue to include counties such as Santa Cruz, Sacramento, and San Diego in the rural Locality 99 designation? We understand that Congress is directing to include our county in a federally sponsored redistricting in 2005. This needs to occur now.

Sincerely,

Shelly W. Young

Submitter : Ms. Shelly Young **Date & Time:** 09/06/2004 05:09:01

Organization : Sutter Maternity and Surgery Center

Category : Nurse

Issue Areas/Comments

GENERAL

GENERAL

Please consider the attached letter.

CMS-1429-P-823-Attach-1.doc

CMS-1429-P-823-Attach-2.doc

CMS-1429-P-824

Submitter : Dr. Pyara Chauhan **Date & Time:** 09/06/2004 06:09:14

Organization : Private Urology Practice (Solo)

Category : Physician

Issue Areas/Comments

Issues 1-9

PRACTICE EXPENSE

I strongly believe that having taken the trouble of collecting very useful data on the cost of acquisition of drugs by physicians, and, establishing an average price for such drugs as Lupron, Zoladex and Eligard, for CMS to promulgate rules to reimburse physicians at a cost lower than the actual acquisition of these drugs is misguided and unfair to both the physicians and the patients they serve. There is no doubt that physicians will no longer purchase the drugs in question leading to disruption of physician/patient relationship. In the longer term such tactics by CMS will inevitably lead to physicians opting out of the Medicaire/Medicaid programs. They will then care only for the patients who can afford the high prices, leaving the rest to fend for themselves. I will venture to advise CMS that no Government sponsored programs will be able to provide as prompt, as cost effective, and as efficient services to these patients as that provided by private physicians. Reducing reimbursement first to 95% of AWP was already unfair. To reduce it further to 85 or 80% of AWP is adding insult to injury.

Thank you for this opportunity to express my views freely.

Pyara Singh Chauhan MD

CMS-1429-P-825

Submitter : Mr. Gregory Clark **Date & Time:** 09/06/2004 07:09:35

Organization : Oliveri Physical Therapy

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I believe that physical therapy services should be provided by licensed physical therapists in all office settings including physician offices. Anyone providing physical therapy services must be graduates of an accredited physical therapy program. I am a physical therapist and I as well as my fellow practitioners have been helping patients in the community for years. We have faced many challenges to our profession in recent years. Show us the respect we deserve and only allow physicians who employ licensed physical therapists to bill for physical therapy services under Medicare.

CMS-1429-P-826

Submitter : Mrs. Lynn King **Date & Time:** 09/06/2004 07:09:16

Organization : Work and rehab

Category : Occupational Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I would like to comment of the August 5 proposed rule on 'Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005.' I strongly support the proposed personnel standards for occupational therapy services that are provided 'indident to ' physician services that are received at the Dr.'s office.Therapy provided as Occupational Therapy should be provided by people who are licensed as OTs, or graduated from an accredited professional Occupational Therapy program. Medicare does not pay for therapy in hospitals and clinics unless it is provided by professional staff. But doctors can bill for it when provided by less trained,unlicensed, unqualfied staff, under the supervision of doctors who usually are not trained in the treatment techniques - this does nothing to help with the problems of fraud. Also,it may delay the recovery of the patient who may not be receiving the optimal therapy program. Only treatment provided by certified, licensed Physical and Occupational Therapists - who are trained to evaluate the patient and prescribe the best course of treatment - should be billed as 'Physical' or 'Occupational Therapy.' If the Dr. wants to provide therapy, it needs to be by a staff licensed to do so.

Lynn King, OTR, CHT Abilene, Texas

CMS-1429-P-827

Submitter : Dr. michael naslund **Date & Time:** 09/06/2004 09:09:25

Organization : university of maryland school of medicine

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

please realize that by lowering the physician reimbursement for LHRH analogs which are used to treat many stages of prostate cancer that patient access will be negatively affected. i am on an academic urology faculty and we will either have to stop offering these treatments completely or offer patients only the 1 month injection instead of the 3 or 4 month injections, the reason this is necessary is that by reimbursing at only cost plus up to 6% the total cost of offering the drug is not covered. in addition, one non-payment (which happens on a regular basis for a variety of reasons) requires 16 paid drug doses to recover the loss. with our fees already low, we cannot and will not afford that loss. the options we have are to make patients come in every month instead of evey 4 months for an injection (with a 1 month dose, the non-payment risk is less substantial because the 1 month dose costs less) or to have them look for someplace where the longer acting doses are being given or to do an orchiectomy (castration) which may be the only treatment option we can afford to offer patients. your desire to save money by lowering access to a prostate cancer drug seems inappropriate.

CMS-1429-P-828

Submitter : Mr. Seth Hansen **Date & Time:** 09/06/2004 09:09:40

Organization : Garrett College

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-828-Attach-1.doc

CMS-1429-P-829

Submitter : Mr. Scott Proscia **Date & Time:** 09/06/2004 09:09:52

Organization : National Athletic Trainers Association

Category : Health Care Provider/Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

Incident to has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician, to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician?s choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient. There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY incident to service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgment of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make decisions in the best interests of the patients.

In many cases, the change to ?incident to? services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient.

This country is experiencing an increasing shortage of credentialed allied and other health care professionals, particularly in rural and outlying areas. If physicians are no longer allowed to utilize a variety of qualified health care professionals working ?incident to? the physician, it is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

Patients who would now be referred outside of the physician?s office would incur delays of access. In the case of rural Medicare patients, this could not only involve delays but, as mentioned above, cost the patient in time and travel expense. Delays would hinder the patient?s recovery and/or increase recovery time, which would ultimately add to the medical expenditures of Medicare.

Curtailing to whom the physician can delegate ?incident to? procedures will result in physicians performing more of these routine treatments themselves. Increasing the workload of physicians, who are already too busy, will take away from the physician?s ability to provide the best possible patient care.

To allow only physical therapists and PT assistants, occupational therapists and OT assistants, and speech and language pathologists to provide ?incident to? services would improperly provide those groups exclusive rights to Medicare reimbursement. To mandate that only those practitioners may provide ?incident to? care in physicians? offices would improperly remove the states? right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.

CMS, in proposing this change, offers no evidence that there is a problem that is need of fixing. By all appearances, this is being done to appease the interests of a single professional group who would seek to establish themselves as the sole provider of therapy services.

CMS does not have the statutory authority to restrict who can and cannot provide services ?incident to? a physician office visit.

Scott Proscia

CMS-1429-P-830

Submitter : Mrs. Mandi Lee **Date & Time:** 09/07/2004 01:09:31

Organization : National Athletic Trainer's Association

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-830-Attach-1.doc

Submitter : Brian Beck **Date & Time:** 09/07/2004 01:09:05

Organization : NATA

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

Submitter : Mrs. Sara Atkinson **Date & Time:** 09/07/2004 02:09:12

Organization : Orthopedic and Sports Medicine Center, Inc.

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Sara Atkinson
OSMC
2310 California Rd.
Elkhart, IN 46514

September 6, 2004

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing in regards to the recent proposal that would limit providers of ?incident to? services in physician owned offices and clinics. If implemented, this would eliminate the ability of qualified health care professionals (i.e. Certified Athletic Trainers), to provide therapy services to Medicare patients.
Please, consider the following information during the decision making process:
? ?Incident to? has, since the inception of the Medicare program in 1965, been utilized by physicians to allow others, under the direct supervision of the physician to provide services as an adjunct to the physician?s professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physicians deems knowledgeable and trained in the protocols to be administered.
? In many cases, the change to ?incident to? services reimbursement would render the physicians unable to provide his or her patients with comprehensive and accessible healthcare. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient. As it stands now with the therapy services in the same facility as the physician if a problem or question does arise there is an immediate line of communication between the health care provider and the physician. This allows the Medicare patient to receive efficient and comprehensive therapy in a safe and timely manner.
? To allow only physical therapists, occupational therapists, and speech and language pathologists to provide ?incident to? outpatient therapy services would improperly provide these groups exclusive rights to Medicare reimbursement. To mandate only these practitioners may provide ?incident to? outpatient therapy in physicians? offices would improperly remove the states? right to license and regulate the allied health care professions deemed qualified, safe and appropriate to provide health care services.
? Athletic trainers are highly educated and qualified to provide the ?incident to? services that are being place in question. ALL certified and/or licensed athletic trainers must have a bachelor?s or master?s degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy percent of all athletic trainers have a master?s degree or higher. This great majority of practitioners who hold advanced degrees are comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other health care professionals. Athletic training academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training and are regulated by these organizations.
In summary, it does not appear necessary or advantageous for CMS to institute the changes proposed. There is currently no evidence that supports this change as being necessary or beneficial to all of those individuals that are involved, including the patient and the quality of health care they

receive. CMS needs to investigate this proposal completely prior to rendering that other health care professionals (i.e. certified/licensed athletic trainers) are not qualified to provide ?incident to? services.

Sincerely,
Sara Atkinson LAT, ATC

CMS-1429-P-833

Submitter : Dr. Oliver Khakmahd **Date & Time:** 09/07/2004 02:09:13

Organization : Dialysis Access Center, Inc.

Category : Physician

Issue Areas/Comments

Issues 20-29

MANAGING PATIENTS ON DIALYSIS

I commend CMS for taking an important step for ESRD beneficiaries by proposing a new G-code, permitting reimbursement for venous mapping for hemodialysis access placement.

My comments are the following:
1. It has become obvious in clinical practice that vessel mapping is critical to both optimizing the identification of vessels in patients who are candidates for an autologous arterio-venous fistula (AVF), as well as to increasing the rate and success of AVF placement and maturation.
2. The current draft rule limits reimbursement for this procedure to the operating surgeon. This is discouraging and limiting to other licensed professionals who are active in the care of dialysis patients. This specific restriction should be revised to permit reimbursement for this procedure based solely on the indication and requirement that this G-code only be used for assessment for AVF placement, and not based on which specialist or facility performs the procedure. With increasing frequency, mapping is being performed by practitioners and licensed providers other than surgeons, including: interventional nephrologists, radiologists, diagnostic vascular laboratories, and diagnostic units. Limiting reimbursement for this G-code exclusively to the surgeon would serve as a barrier to increasing the AVF rate in this country, as it would prevent the majority of incident hemodialysis patients from being adequately evaluated for AVF placement where this service is not provided by a surgeon.
3. Venous mapping usually is not complete and requires limited assessment of the arteries for creation of an arterio-venous fistula. Therefore, it is suggested that
'vein' mapping be replaced by 'vessel' mapping to be inclusive, or add additional G-Code for arterial mapping.
4. The proposed G-code language should be changed so that reimbursement is not be restricted to Doppler ultrasound mapping, as circumstances often require use of contrast or other mapping methods (which, incidentally, are not performed by surgeons).
5. Consider replacing 'graft' with 'fistula' in the G-code description, as the latter would cover all autogenous procedures, whereas 'graft' may confuse the issue by implying that only certain types of planned AVF procedures would qualify for reimbursement under this G-code.

Thank you for taking this important step to improve the care of hemodialysis vascular access in our patients.

Oliver Khakmahd, MD
Medical Director
Dialysis Access Center, Inc.

CMS-1429-P-834

Submitter : Mr. Arnold Arrieta **Date & Time:** 09/07/2004 03:09:05

Organization : AthletiCo Rehabilitation

Category : Health Care Provider/Association

Issue Areas/Comments

Issues 10-19

DEFINING THERAPY SERVICES

I am writing this letter vehemently opposing any legislation or proposal that would limit the use of qualified, allied health care professionals, specifically Certified Athletic Trainers, in physician offices or outpatient clinics. As both a Certified Athletic Trainer and a Physical Therapist in the State of Illinois, I find no reason to amend current legislation and regulation of health care providers in outpatient settings. As the old adage goes, 'If it ain't broke, don't fix it.' By amending current legislation, it appears that the government is again attempting to take away the ability of patients and physicians to choose who is appropriate and qualified to assist in their rehabilitation and recovery. A physician has the right to delegate the care of his or her patients to trained individuals (including Certified Athletic Trainers) whom the physician deems appropriate and skilled in the protocols to be administered. I question the rationale in attempting to amend current legislation allowing specific health care professionals (physical therapists/assistants, occupational therapists/assistants, and speech patholigists)exclusivity in providing outpatient rehabilitation services. If education and skill level of specific health care professionals (ie. Certified Athletic Trainers) is in question, CMS must realize that they are 'taking a step back' by limiting outpatient rehabilitation to select, aforementioned providers. To further illustrate differences in education, all Certified Athletic Trainers have a Bachelor's or Master's Degree. Physical Therapy Assistants need only a two year Associate's Degreee. Prior to recent changes in accreditation of Athletic Training programs, all Certified Athletic Trainers required one thousand, five hundred internship hours prior to sitting for examination. Currently, some physical therapy programs require only one thousand, two hundred hours of internship prior to sitting for examination. Additionally, board examination for Athletic Trainers require a three-part oral, written, and written simulation portions versus only a written multiple choice board examination for Physical Therapists. Finally, the National Athletic Trainer's Association, the govering board for Certified Athletic Trainers, require eighty hours of continuing education every two years prior to re-licensure/membership renewal. Some states have only more recently added continuing education hours for Physical Therapists prior to relicensure, while other states require none at all!!! I strongly urge CMS to reconsider any possible amendments to current legislation. Any future proposals must appeal to a wider scope of qualified health care professionals in regards to providing outpatient therapy services. Being both a member of the organizational bodies of Certified Athletic Trainers and Physical Therapists (NATA and APTA respectively) it is my belief that the CMS proposal would restrict consumers and physicians from making health care decisions which in turn could seriously limit the marketplace, increase health care costs, and inhibit the quality of heath care provided.

Sincerely,

Arnold L. Arrieta, MPT, ATC/L, CSCS

Submitter : Ms. Lorane Stitcher **Date & Time:** 09/07/2004 04:09:47

Organization : APTA

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I strongly feel that payment for services provided by unlicensed employees should not be rendered. Applying modalities is not providing physical therapy. Our field now requires a master's degree for entry level, which should alone exclude payment for these services. Modalities only performed as treatment by someone without education on anatomy, physiology, etc, without proper patient education and progressive exercises, as well as evaluation and reassesments is at best a waste of money.

CMS-1429-P-836

Submitter : Dr. Stefan Montgomery **Date & Time:** 09/07/2004 11:09:36

Organization : Stefan L. Montgomery Family and Sports Medicine

Category : Physician

Issue Areas/Comments

Issues 10-19

DEFINING THERAPY SERVICES

I believe that Athletic Trainers should be allowed to bill incident to charges for therapy that they provide directly to patients. They are a recognized allied health professional association and have a national certification for credentialing. Additionally, in South Carolina the Athletic Trainers are required to be licensed by the state. These providers are skilled at the prevention, treatment, and rehabilitation of injuries. They should be allowed to perform their well developed skills and use their knowledge to bill incident to for physical therapy services that are within their scope of practice.

CMS-1429-P-836-Attach-1.doc

Submitter : Miss. Amy Basha **Date & Time:** 09/07/2004 12:09:59

Organization : NATA

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

I am completing this form as my duty as an athletic trainer and all of my fellow athletic trainers

CMS-1429-P-838

Submitter : Mr. Chuck Whedon **Date & Time:** 09/07/2004 12:09:24

Organization : Rowan University

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

This is an example of awry governmental health care regulation. Physicians, not government workers, should decide what care and treatment are in the best interests of their patients, and who should provide it.
Athletic trainers' education and scope of practice ensure they are expert providers of outpatient therapy services. It is a function they perform many times each day. To say an athletic trainer can't walk across the street from the collegiate athletic training room to the physician's office to administer the same therapy treatment to an older patient who has sprained an ankle jogging or walking the athletic trainer just provided to a track athlete just doesn't make sense.

CMS-1429-P-839

Submitter : Dr. Richard Morrissey **Date & Time:** 09/07/2004 01:09:05

Organization : North Shore-Long Island Jewish Health System

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support the idea of Psychologists being able to supervise psychological and neuropsychological testing administered by nonlicensed personnel.

Submitter : Dr. George Phillips **Date & Time:** 09/07/2004 01:09:33

Organization : Oakwood Urology

Category : Physician

Issue Areas/Comments

GENERAL

GENERAL

A 13% reduction in one year seems a little severe. Couldn't this be phased in over 5 -7 years more fairly? If the 13% reduction does occur, our office will probable have to compensate by dropping health insurance for our employees. This is not something we had hoped to do.

CMS-1429-P-841

Submitter : Mr. Christopher Nawrocki **Date & Time:** 09/07/2004 01:09:03

Organization : The Center for Physical Rehabilitation

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

I strongly support the new CMS proposal that individuals who furnish outpatient physical therapy services in physician offices must be graduates of an accredited professional physical therapist program. PT's and PTA's under the supervision of a physical therapist are the only caregivers qualified to deliver PT services. They are the ones who have spent their full academic time in training to provide PT services. PT's and PTA's understand what is deemed medically necessary and skilled care when billing for PT services. PT's have rigorous undergraduate and graduate curriculum in order to practice. We have our own national association, APTA, and we are required to abide by the code and ethics of this association. It is poor health care to allow the delivery of physical therapy services by anyone other than a qualified PT or PTA. Physicians for years have been able to bill for services with unqualified personnel and get a higher reimbursement rate than a PT who is licensed and graduated from an accredited PT program. The time has come to change the face of our healthcare system and let the qualified individuals of different professions deliver the needed care and be the only ones to bill for it. Consumer costs continue to be driven up in many healthcare areas and as a practicing private PT I cannot fathom for the life of me why physicians can bill for my profession when they have little to no knowledge of PT, can use unqualified personnel to deliver "PT" services and then bill and get reimbursed a higher rate than any truly qualified PT. The "incident to" ruling would be a step in the right direction to weed out fraud and abuse in our Medicare system.

Thank you for your time and attention in this most serious matter.

Sincerely,

Chris Nawrocki, PT,MS,OCS
Director of Operations
The Center for Physical Rehabilitation

Submitter : Mr. Jerry Shaw **Date & Time:** 09/07/2004 02:09:25

Organization : Hughston Rehabilitation

Category : Physical Therapist

Issue Areas/Comments

GENERAL

GENERAL

September 7, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy ? Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services.

As a licensed physical therapist I feel that certified athletic trainers have the educational background and clinical skills necessary to provide quality therapy to patients, across the age span. I have worked closely with certified athletic trainers throughout my career and have personally witnessed their skills and effectiveness. Eliminating access to these professionals would be a severe loss for Medicare patients.

Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor?s or master?s degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master?s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries. In addition, dozens of athletic trainers will be accompanied the U.S. Olympic Team to Athens, Greece this summer providing these services to the top athletes from the United States. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

I firmly believe that the physical medicine CPT codes are intended for use by qualified health care providers, and that certified athletic trainers are as qualified as physical therapists and more qualified than physical therapy assistants to provide these services.

I strongly oppose the proposed policy change and urge its withdrawal.

Sincerely,

Jerry Shaw, PT
Director of Hughston Rehabilitation
Auburn, AL

CMS-1429-P-843

Submitter : Mr. Adam Annaccone **Date & Time:** 09/07/2004 02:09:54

Organization : NATA

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please See Attached

CMS-1429-P-843-Attach-1.doc

CMS-1429-P-844

Submitter : **Date & Time:** 09/07/2004 02:09:42

Organization : National Athletic Trainers' Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file.

CMS-1429-P-844-Attach-1.doc

Submitter : Miss. Catherine Hale **Date & Time:** 09/07/2004 03:09:05

Organization : Kent State University

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-845-Attach-1.doc

Submitter : Mr. Nathan Place **Date & Time:** 09/07/2004 03:09:30

Organization : Excel Sports

Category : Other Health Care Professional

Issue Areas/Comments

GENERAL

GENERAL

Nathan Place
Excel Sports
4800 Mexico Road
St. Peters, MO 63376

September 7, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

Re: Therapy - Incident To

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of "incident to" services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

During the decision-making process, please consider the following:

- "Incident to" has, since the inception of the Medicare program in 1965, been utilized by physicians to allow other, under the direct supervision of the physician, to provide services as an adjunct to the physician's professional services. A physician has the right to delegate the care of his or her patients to trained individuals (including certified athletic trainers) whom the physician deems knowledgeable and trained in the protocols to be administered. The physician's choice of qualified therapy providers is inherent in the type of practice, medical subspecialty and individual patient.

- There have never been any limitations or restrictions placed upon the physician in terms of who he or she can utilize to provide ANY "incident to" service. Because the physician accepts legal responsibility for the individual under his or her supervision, Medicare and private payers have always relied upon the professional judgement of the physician to be able to determine who is or is not qualified to provide a particular service. It is imperative that physicians continue to make dicisions in the best interests of the patients.

- Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor's or master's degree from an accredited college or university. Foundations courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. All programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

- CMS does not have the statutory authority to restrict who can and cannot provide services "incident to" a physician office visit.

In addition to these significant points, the "sports medicine" model of treating patients can be negatively effected by this proposed change. Sports medicine is not a profession or a certain technique. It is a model used by me and my current employer that promotes the use of several medical disciplines, as a team, to efficiently and effectively treat patients. Should this proposal pass, our ability to treat our patients in such a way (which is also very cost effective) will greatly be affected in a negative way.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterent.

Sincerely,
Nathan Place, ATC

Submitter : Miss. Jennifer Stiller **Date & Time:** 09/07/2004 03:09:36

Organization : University of Kentucky

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician offices and clinics. As a student pursuing my Master?s degree in the profession of athletic training, I am particularly disappointed by this proposal. CMS is basically sending a message that my future profession is not eligible to be considered a true health care profession. Athletic trainers have all the necessary skills to provide care for the population we service. In addition, we are equipped with advanced skills in functional return-to-activity for athletes that are unique to our profession. Athletic trainers are educated and competent, as is evidenced by the great number of athletic trainers with advanced degrees such as Master?s and doctorates. Athletic trainers should therefore remain a viable alternative for doctors referring their patients for physical rehabilitation.
This ?incident to? proposal should not be adopted because qualified health care professionals would no longer be able to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.
During the decision-making process, please consider the following:
?In many cases, the change to ?incident to? services reimbursement would render the physician unable to provide his or her patients with comprehensive, quickly accessible health care. The patient would be forced to see the physician and separately seek therapy treatments elsewhere, causing significant inconvenience and additional expense to the patient. It is likely the patient will suffer delays in health care, greater cost and a lack of local and immediate treatment.

?Athletic trainers are highly educated. ALL certified or licensed athletic trainers must have a bachelor?s or master?s degree from an accredited college or university. Foundation courses include: human physiology, human anatomy, kinesiology/biomechanics, nutrition, acute care of injury and illness, statistics and research design, and exercise physiology. Seventy (70) percent of all athletic trainers have a master?s degree or higher. This great majority of practitioners who hold advanced degrees is comparable to other health care professionals, including physical therapists, occupational therapists, registered nurses, speech therapists and many other mid-level health care practitioners. Academic programs are accredited through an independent process by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) via the Joint Review Committee on educational programs in Athletic Training (JRC-AT).

?CMS does not have the statutory authority to restrict who can and cannot provide services ?incident to? a physician office visit. In fact, this action could be construed as an unprecedented attempt by CMS, at the behest of a specific type of health professional, to seek exclusivity as a provider of therapy services.

?Athletic trainers are employed by almost every U.S. post-secondary educational institution with an athletic program and every professional sports team in America to work with athletes to prevent, assess, treat and rehabilitate injuries sustained during athletic competition. For CMS to even suggest that athletic trainers are unqualified to provide these same services to a Medicare beneficiary who becomes injured as a result of walking in a local 5K race and goes to their local physician for treatment of that injury is outrageous and unjustified.

In summary, it is not necessary or advantageous for CMS to institute the changes proposed. This CMS recommendation is a health care access deterrent.

Sincerely,
Jennifer Stiller, ATC-L
Graduate Assistant Athletic Trainer, University of Kentucky

CMS-1429-P-848

Submitter : Mrs. Mary Elizabeth Lamb **Date & Time:** 09/07/2004 04:09:39

Organization : Doctors Hospital of Augusta

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Dear Sir/Madam:

I am writing to express my concern over the recent proposal that would limit providers of ?incident to? services in physician offices and clinics. If adopted, this would eliminate the ability of qualified health care professionals to provide these important services. In turn, it would reduce the quality of health care for our Medicare patients and ultimately increase the costs associated with this service and place an undue burden on the health care system.

CMS-1429-P-848-Attach-1.doc

CMS-1429-P-849

Submitter : Dr. Valerie Shebroe **Date & Time:** 09/07/2004 05:09:51

Organization : Valerie L. Shebroe, Ph.D., Psychologist

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am in support of psychologists being able to independently supervise administration of psychological and neuropsychological tests. I believe that this will help with more efficient delivery of diagnostic mental health services and increase services in rural and underserved areas which already are underserved by mental health professionals, including psychiatrists and psychologists. Particularly since psychologists are trained at the graduate and post-graduate level to administer psychological and neuropsychological tests, they are most qualified to provide independent supervision. Thank you for reading these comments. Sincerely, Valerie L. Shebroe, Ph.D., Psychologist in Independent Practice

Submitter : Dr. Daniel A. Martell **Date & Time:** 09/07/2004 05:09:28

Organization : National Academy of Neuropsychology

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am writing in support of the CMS rule change regarding outpatient supervision of technicians by psychologists. This is a practice critical issue that deserves full support.

CMS-1429-P-851

Submitter : Dr. Neil Pliskin **Date & Time:** 09/07/2004 05:09:56

Organization : Dr. Neil Pliskin

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

Thank you for the opportunity to comment on this very important matter.

Submitter : Dr. Karen Miller **Date & Time:** 09/07/2004 05:09:43

Organization : Infinity Health Care and UCLA

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists should be allowed to provide services via a registered technician.

CMS-1429-P-853

Submitter : Dr. Karen Dahlman **Date & Time:** 09/07/2004 05:09:23

Organization : Mount Sinai School of Medicine

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists have the greatest level of expertise in testing and therefore are the best qualified to supervise others performing such tests. I support the rule change.

CMS-1429-P-854

Submitter : Dr. Wendy Ringe **Date & Time:** 09/07/2004 05:09:45

Organization : UT Southwestern Medical Center at Dallas

Category : Physician

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am in support of the CMS rule change regarding outpatient supervision of technicians.

Submitter : Dr. Nancy Voight **Date & Time:** 09/07/2004 05:09:00

Organization : Self Regional Healthcare

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists, as independent health care providers, need to be able to supervise their own psychometry staff providing psychological testing. No physician or other health care professional is qualified to conduct psychological testing without a psychologist.

CMS-1429-P-856

Submitter : Dr. Steven Smith **Date & Time:** 09/07/2004 05:09:19

Organization : Dr. Steven Smith

Category : Academic

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support the change to allow psychologists to supervise psychological testing

Submitter : Dr. Michael Lavoie **Date & Time:** 09/07/2004 05:09:04

Organization : Phoenix Children's Hospital

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists have on average seven years of graduate education and are highly skilled in the selection, administration, and interpretation of psychological tests. The CMS rule change regarding outpatient supervision of technicians will allow psychologists to supervise ancillary staff, which would ensure that practitioners with a higher level of expertise in testing would provide oversight. Allowing psychologists to supervise testing in rural areas would reduce delays in testing, diagnosis and treatment that may result because physicians are unavailable to supervise tests. I wholeheartedly support of the CMS rule change regarding outpatient supervision of technicians.

CMS-1429-P-858

Submitter : Dr. Alexander Troster **Date & Time:** 09/07/2004 05:09:43

Organization : University of North Carolina School of Medicine

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

The utilization of technicians (preferably psychometrists) to administer and score psychological tests under the supervision of licensed psychologists is consistent with the use of technicians in other areas of health care (e.g., radiology technicians). The proposed change should be supported because licensed psychologists are probably the best qualified to supervise psychological test administration and scoring by virtue of their training and experience. The proposed change should also be supported as it would probably lead to more efficient and economical use of this health care resource and greater availability of services in underserved areas.

CMS-1429-P-859

Submitter : Dr. gary warner **Date & Time:** 09/07/2004 05:09:28

Organization : Dr. gary warner

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Iam in support of the CMS rule change regarding outpatient supervision of technicians. .Psychologists should be qualified to supervise psychology technicians. It makes no compelling sense to say that a MD is qualified in this manner and a psychologist is not. Psychology technicians serve as lab technicians in the practice of psychological assessments. Therefore, psychologists are the lone professional group capable of supervising them. Technicians serve in this area serve functionally the same way X-ray or other lab technicians do. They are important to the efficiency by which data are collected.

CMS-1429-P-860

Submitter : Dr. Michael Santa Maria **Date & Time:** 09/07/2004 05:09:17

Organization : Dr. Michael Santa Maria

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

This letter is in support of guidelines specifying use of technicians/extenders in psychological assessment.

Individuals providing technician services objectively administer and score standardized test instruments. They do not call themselves psychologists or counselors and are not practicing independently. They obtain objective data and are specifically prohibited by national guidelines and hospital allied health worker regulations from providing diagnosis, treatment, counseling or psychotherapy. The use of technicians in diagnostic assessment has been an established practice standard in the field of clinical neuropsychology for over thirty years and is endorsed and supported by governing bodies in the field [e.g., DeLuca, J.W. (1989). Neuropsychology technicians in clinical practice: Precedents, rational and current deployment. The Clinical Neuropsychologist, 3(1), 3-21.]

Specifying that technicians are to be used for psychological and neuropsychological assessment would be consistent with other procedures that employ technicians: CT, MRI, PET, EEG, Doppler imaging. Likewise, technicians in these disciplines are not practicing medicine or claiming to. Just as their job is to obtain the data for the radiologist, the job of a psychological or neuropsychological technician is to obtain data for the neuropsychologist.

Just as it is unnecessary for a radiologist to personally obtain imaging, and unreasonable because of time constraints, the same holds true for many psychologists and neuropsychologists. This is of particular concern in rural and other underserved areas where service providers are lacking.

Thank you.

Submitter : Dr. Munro Cullum **Date & Time:** 09/07/2004 05:09:08

Organization : UT Southwestern Med. Ctr.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

This type of diagnostic testing should appropriately be supervised by clinical psychologists and neuropsychologists, who have the relevant expertise in this area. Psychologists have the psychometric background through years of doctoral study to understand test development, are the primary authors of these tests, and and the primary users. Given their 4-5 years of graduate school, 1 year clinical internship, and 1-2 years of postdoctoral residency, psychologists are by far the most well-qualified users of these tests. Most psychological tests were in fact developed by psychologists, who have the psychometric, statistical, and clinical backgrounds to develop, apply, and interpret these tests. Their training background in psychological testing is unequalled in medical and other allied health settings, and no one is better qualified to utilize these important diagnostic instruments. Thus, psychologists should be primarily responsible for the application of such measures and should be granted the appropriate authority to supervise their use.

CMS-1429-P-862

Submitter : Dr. Vickie Brewer **Date & Time:** 09/07/2004 05:09:59

Organization : Center for Pediatric Neuropsychology

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly urge you to revise the current standards that do not allow Psychologists to supervise technicians. M.D.'s have no training in test administration, have never given the tests that this rule applies to, and in many circumstances would not even be allowed to purchase the tests in question. M.D.'s should not be supervising individuals in the administeration and interpretation of procedures outside their area of expertise. I am Director of Neuropsychology at Le Bonheur Children's Hospital and in private practice. By the time I started practicing independently, I had 6 years of coursework on test administration and interpretation. Additionally, I had 6 years of extensive experience in administering psychological tests to a wide range of brain injured individuals, 1 year of residency, and 1 year of post-doctoral fellowship. M.D.'s have had zero tests in test construction and interpretation and have never administered any of the tests. Unlike laboratory tests, one must learn what these tests are, their limitations, and how to administer them before being able to supervise someone on those same issues.

Submitter : Dr. Thomas Burns **Date & Time:** 09/07/2004 05:09:18

Organization : Children's Healthcare of Atlanta

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

I am in complete support for incident to services.

THERAPY STANDARDS AND REQUIREMENTS

Psychological Testing needs more support (#26)

Submitter : Dr. Jim Hom **Date & Time:** 09/07/2004 05:09:46

Organization : The Neuropsychology Center

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly endorse the proposed change as outlined in CMS-1429-P. Clinical psychologists receive 7 years on average of post-baccalaureate coursework and practica, including a one-year supervised clinical internship. Many states require an additional, post-doctoral year of supervision prior to granting licensure. Neuropsychologists receive training in the neurosciences and psychology, and many complete the practica, internships, and post-doctoral training at medical schools and health science centers around the country. In their education, training, and experience, neuropsychologists and psychologists gain particular expertise in psychological and neuropsychological diagnostic testing. This includes knowledge and expertise regarding test measurement and development, psychometrics, test selection, administration, and interpretation, and clinical psychological and neuropsychological diagnostics. As such, I believe clinical psychologists, including neuropsychologists, are appropriately and uniquely qualified to supervise diagnostic psychological testing by ancillary staff.

Submitter : Dr. Dixon Miller **Date & Time:** 09/07/2004 05:09:01

Organization : Acadia, Inc.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly support allowing licensed psychologists to supervise the administration and scoring of psychological/neuropsychological tests by trained technicians operating under that supervision. Psychologists, after all, are specifically and extensively trained in the development, administration, scoring and interpretation of psychological test, while physicians (psychiatrists included) are not.

Submitter : Dr. Charles Golden **Date & Time:** 09/07/2004 05:09:06

Organization : Nova Southestern University

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

The change to allow psychologists to superviser is long overdue/ Psychologists have more training in the giving and interpretation of diagnostic psychological tests than do physicians (who often have none at all). The current system has led to both increased costs as well as poor delivery of service in both urban and rural areas. The change will allow for wider dissemenation of sevrices and equally important will allow for a higher quality of service at a comaprable or lower cost.

CMS-1429-P-867

Submitter : Nancy LaFon **Date & Time:** 09/07/2004 05:09:52

Organization : National Athletic Trainers' Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

Please see attached file

CMS-1429-P-867-Attach-1.doc

CMS-1429-P-868

Submitter : Dr. Robert Bilder **Date & Time:** 09/07/2004 05:09:43

Organization : UCLA Neuropsychiatric Institute

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

The proposed modification is crucial to permit the future availability of quality psychological services to a large number of patients. The new regulation offers major advantages over the current rules that prohibit many centers from being able to offer such services at all. Psychologists have well established guidelines for providing outstanding supervision for their supervisees, and these guidelines are routinely enforced by both professional organizations and state licensing authorities. There is thus no apparent risk, and a major benefit to Medicare beneficiaries. Additionally, the proposed change may benefit the training of less experienced psychologists who will go on to provide services to currently underserved populations.

CMS-1429-P-869

Submitter : Dr. Wayne Adams **Date & Time:** 09/07/2004 05:09:32

Organization : George Fox University and Providence Newberg Hospi

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Allowing licensed practitioners to utilize appropriately trained, non-doctoral-level, reimbursed assistants is a way to reduce healthcare costs and extend psychologists' expertise to more clients, both with little or no reduction in quality or risk. The model is used in most other healthcare professions, and provisions are made in most states' licensing laws on how to regulate and provide oversight to these healthcare extenders.
In addition to my university training position, I also am on the staff at our local community hospital. By allowing well-trained non-doctoral level providers to be supervised by me, I would be able to extend services to many more medicare recipients and at lower cost than is currently possible. For example, it is common for the poor or elderly to need various assessments to better understand their disorders (e.g., depression, dementia, etc.). Using available psychological tests allows me to better diagnose and more rapidly begin the appropriate treatment of these clients. (The psychological test results are useful in a way similar to physician's test results, with respect to increasing and expediting diagnostic accuracy.) Like many mental health works serving in rural or semi-rural areas, my time is limited while consulting at my community hospital. Allowing me to use reimbursable psych testing service extenders would increase my ability to serve more clients, while providing higher levels of helpful diagnostic precision, while keeping costs down. Thank you for considering this change in the reimbursement guidelines.

CMS-1429-P-870

Submitter : Dr. Ronald M. Lazar **Date & Time:** 09/07/2004 05:09:05

Organization : Columbia Univ College of Physicians

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

As a neuropsychologist and a full professor in the Departments of Neurology and Neurological Surgery at the Neurological Institute of Columbia College of Physicians & Surgeons, I am called upon to perform diagnostic psychological tests by my physician colleagues. They have uniformly recognized that professionals in my field have the specific background and experience to administer psychological tests and to supervise others performing such tests. At the New York Presbyterian Hospital where I see patients, for example, only psychologists such as myself are formally credentialed by the institution's Medical Board to give these tests, a recognition that we uniquely have the experience to give and supervise their administration. My credentials include 10 years of graduate training, residency and fellowship, and more than 125 publications in the world's most renowned medical literature. I fully agree with CMS' acknowledgement that having psychologists supervise ancillary staff would ensure that practitioners with a higher level of expertise in testing would provide oversight. I therefore vigorously support the rule change to enable psychologists to supervise others, such as technicians, giving these tests.

Submitter : Dr. Mark Rohrscheib **Date & Time:** 09/07/2004 05:09:55

Organization : University of New Mexico School of Medicine

Category : Physician

Issue Areas/Comments

Issues 1-9

SECTION 613

Section 613 Comments

The following comments are germane to the recently issued proposed rules related to section 613 of the Medicare Modernization Act (MMA). I am concerned that there are certain provisions within the proposed rule that may delay access to tests developed in the future. Specifically, I would like to comment on the proposed rule to impose a National Coverage Decision process on new tests that are developed and approved for use by the FDA for diabetes screening.

Section 613 of the MMA requires CMS to cover fasting plasma glucose tests, oral glucose tolerance tests and other such tests that the Secretary of Health and Human Services deems appropriate. When future diabetes screening tests are cleared by the Food and Drug Administration (FDA), they will have automatically been deemed appropriate for their intended use by the Secretary of HHS after review of the relevant regulatory filings and consultation with appropriate organizations such as the ADA and AACE. When you consider that Congress has already legislated coverage for diabetes screening, it seems unnecessary for CMS to impose future FDA-cleared diabetes screening tests to another NCD process. This is especially true when you consider that the FDA typically consults these same organizations prior to granting market clearance. I believe that requiring an NCD process for new diabetes screening tests will add inefficiency to the Medicare coverage process more efficient at a time when CMS is taking other measures to improve its internal efficiencies. As well, doing so would unnecessarily delay access to innovative screening technologies in the future.

It seems logical that if new tests have been cleared by the FDA for the expressed purpose of diabetes screening then they have also been deemed appropriate by the Secretary of HHS. Therefore, I am recommending that CMS rewrite the regulations by removing the -subject to NCD process- provision and instead allow for new diabetes screening tests that have been approved by the FDA to be also covered without subjecting the new test to a new NCD process.

CMS-1429-P-872

Submitter : Dr. Michael Howard **Date & Time:** 09/07/2004 05:09:21

Organization : Dr. Michael Howard

Category : Physician

Issue Areas/Comments

Issues 1-9

PRACTICE EXPENSE

It is just incomprehensible to me that while all of our expenses to practice medicine (ie medical malpractice, Supplies, staff, cost of living) are continuously rising, that I have taken a pay cut every year since I have been in practice. The government has to worry about rising medical costs, physician fees are only a small portion of the total amount. In what other business are rising overhead costs not passed on to the consumer. I went into medicine because I loved it. Like many of my peers I feel forced to make a choice. We can either no longer participate with those insurance plans that are not being fair to us as physicians or no longer practice medicine. Staying with plans that continuously lower reimbursements is no longer an option. Dropping plans could can leave even more people without good health care options and drive up the use of emergency room visits and the overall cost of healthcare. I know in Florida alot of physicians have been dropping medicare for this reason. I think this is also driving alot of physicians to see alot more patients to reduce the loss of revenue, but it has a tremendous effect on the quality of medicine that can be practiced. It becomes to easy to practice bad medicine and to make mistakes. Many residency programs are not filling their spots because of the increased stress and decreased ability to enjoy the field of medicine. I chose medicine because I love it, but not at the cost of feeling abused. This choice of continuously dropping plans or giving up medicine is something I agonize over. No physician expects fees to go back to where they were in the 70's. However, I have to give my staff a raise periodically. the cost of everything I buy for the office has increases. My expenses outside the office are continuously rising. How or why am I expected to pay these increases on less?

CMS-1429-P-873

Submitter : Dr. Anthony Stringer **Date & Time:** 09/07/2004 05:09:47

Organization : Emory Healthcare

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a clinical neuropsychologist. I wish to express my very strong support for the proposed rule change that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessment services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients by improving their access to psychological and neuropsychological assessment services.

Thank you for the opportunity to comment on this very important matter.

Submitter : Dr. Linda Laatsch **Date & Time:** 09/07/2004 05:09:52

Organization : University of Illinois College of Medicine

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Clinical Psychologists have completed at least four years of training involving psychological testing, statistics, and interviewing skills. In addition, they have complete 3-5 years of supervised testing practicum experiences. Therefore, a clinical psychologist is the proper and most appropriate supervisor of psychological testing given their extensive experience in the complex area of testing.
In contrast physicians do not have experience in testing even when they are part of a related specialty, such as neurology. I am part of the faculty involved in exposing our neurology trainees to psychological testing. It is required that they have exposure to psychological testing, not training in psychological testing, therefore they only receive a few hours of lecture time on the subject. A physician is not adequately prepared to supervise psychological testing.

Submitter : Dr. Sid Dickson **Date & Time:** 09/07/2004 05:09:40

Organization : Pate Rehabilitation

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists/Neuropsychologists are qualified to supervise diagnostic testing (psychological/neuropsychological) by psychological technicians/psychometrists. Psychologists/neuropsychologists have the greatest level of expertise in testing and therefore are the best qualified to supervise others performing such tests.

CMS-1429-P-876

Submitter : Dr. Philip Harvey **Date & Time:** 09/07/2004 05:09:17

Organization : Mt. Sinai School of Medicine

Category : Academic

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists have the greatest level of expertise in testing and therefore are the best qualified to supervise others performing such tests. I support the rule change.

Submitter : Dr. Valerie Masten Hoese **Date & Time:** 09/07/2004 05:09:44

Organization : Valerie Masten Hoese, Ph.D.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am writing to support changing this regulation such that psychologists and neuropsychologists would be the only source to review/supervise the work of technicians. Psychologists/neuropsychologists are the only health care professionals who possess the necessary background and educational training to provide this supervision. By changing this policy, the public will receive better service and protections. Assessment and scoring and interpretation are complicated matters that require course work and continuing education to have the skill necessary to apply statistical and psychometric knowledge to the selection, scoring, and particularly the interpretation of psychological and neuropsychological tests. No other profession receives this type of education as part of the degree process and it is unclear how this rule ever was written in the way that it was, with psychologists not being the professionals responsible for the supervision of technicians. I very much support this change. Thank you,
Valerie Masten Hoese, Ph.D. Clinical Neuropsychologist

Submitter : Dr. Sandra Kindermann **Date & Time:** 09/07/2004 05:09:54

Organization : University of California, San Diego

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support the use of qualified psychometrists to perform psychological and neuropsychological assessments when supervised by a licensed psychologist practicing within the ethical guidelines regarding competency.

Submitter : Dr. Franklin Brown **Date & Time:** 09/07/2004 05:09:48

Organization : Dr. Franklin Brown

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a clinical neuropsychologist who in addition to the numerous psychological testing courses required during my Ph.D. received additional neuropsychological training. Clearly, a Ph.D. level psychologist is the most appropriate to supervise and interpret psychological tests. Physicians receive NO formal training in psychological testing durnig their formal coursework. IF they have any exposure during residency, this is incidental and clearly not even close to that training which a psychologist receives.

I think the term 'physician' should be removed from any legislature in regards to those who are reimbursed for supervising psychological testing. I would certainly not claim to be able to interpret many tests that medical doctors administer (e.g, blood work, etc) and I think it must be recognized that physicians should be required by law to practice within their scope of training also. Within these guidelines of scope of practice, only psychologists receive the formal coursework necessary to adequately supervise administration and interpretation of psychological tests. Thank you for your time.

Sincerely,
Franklin C. Brown, Ph.D.

Submitter : Dr. Theresa Covington **Date & Time:** 09/07/2004 05:09:13

Organization : Institute of Living/Hartford Hospital

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

It is critical that licensed psychologists and neuropsychologists be allowed to employ and bill for the time of technicians in assessments. By approving this practice, access to the expertise of psychologists/neuropsychologists will be increased with overall benefit to healthcare for individuals suffering from psychiatric, behavioral and medical problems requiring psychological and/or neurocognitive assessment. For example, the most effective way of identifying the early stages of dementia is through a neuropsychological evaluation. With the limited availability of neuropsychologists, providers are relying on quick screens and often providing either inaccurate diagnoses or missing the diagnosis due to the crude assessment that these measures provide.

Psychologists/neuropsychologists have an established practice of training and supervising technicians to assist with the administration and scoring of tests. Guidelines already exist for the ethical and professional use of technicians in the provision of psychological/neuropsychological assessment. In these guidelines, the clinical interview, selection of the assessment instruments to be used, interpretation, and writing of reports, remains the responsibility of the licensed professional.

Thank you for seriously considering this request to allow these licensed professionals to oversee certain aspects of their profession that lend themselves to the use of technicians.

Submitter : Dr. Kevin Duff **Date & Time:** 09/07/2004 05:09:32

Organization : Dr. Kevin Duff

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.

My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

Thank you for the opportunity to comment on this very important matter.

Sincerely, Kevin Duff, Ph.D.

Submitter : Dr. Geoffrey Tremont **Date & Time:** 09/07/2004 05:09:43

Organization : Rhode Island Hospital

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for this proposed rule change (that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. I specialize in the application of assessment and intervention principles based on the scientific study of human behavior across the lifespan as it relates to both normal and abnormal functioning of the central nervous system. By virtue of my doctoral-level academic preparation and training, I possess specialized knowledge of psychological and neuropsychological test measurement and development, psychometric theory, specialized neuropsychological assessment techniques, statistics, and the neuropsychology of behavior (among others). Other health care providers (e.g., psychiatrists, neurologists) address these same patients' medical problems. However, our medical colleagues have not had the specialized knowledge and training (enumerated above) that is needed to safely direct the selection, administration, and interpretation of psychological and neuropsychological testing and assessment procedures in the diagnosis and care of Medicare and Medicaid patients.
My education and training uniquely qualifies me to direct test selection and to perform the interpretation of psychological and neuropsychological testing results that have been collected by non-doctoral personnel that assist with the technical aspects of psychological and neuropsychological assessments (i.e., administering and scoring the tests that I indicate). I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessments services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

CMS-1429-P-883

Submitter : Dr. Raymond DiPino **Date & Time:** 09/07/2004 05:09:44

Organization : West Virginia School of Medicine-Charleston

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am writing to support the proposed rule change that would allow psychologists to supervise the administration of psychological and neuropsychological testing. In training as a neuropsychologist, I received 8 years of specialized training in psychology with a strong emphasis on psychological assessment, including test construction, test design, and statistical analysis. I, like most of those who have received similar training, have developed considerable expertise in the selection, administration, and interpretation of psychological tests. I believe that psychologist as a group are the most highly qualified individuals to provide supervision of such assessement services and have a degree of training and experience that far exceeds physicians in this area. I believe that individuals served by Medicaid and Medicare benefit from having supervision of any services they receive provided by the best qualified individuals in the given area of service. In the area of psychological assessment, I believe Psychologist have the most appropriate and relevant training and experience and are best quilified to supervise those engaged in providing these services. Thank you for the opportunity to provide my comments on this important issue.

CMS-1429-P-884

Submitter : Dr. Robert Velin **Date & Time:** 09/07/2004 05:09:25

Organization : Montana Neurobehavioral Specialists

Category : Health Care Professional or Association

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support a change allowing for supervision of psychological technicians by the treating psychologist. The practice of psychology, as defined in the states, assures competence of the professional psychologist withing their area of specialty. Part of this entails supervision of technicians who are completing tests as part of comprehensive psychological and neuropsychological batteries. Limiting the supervisorial scope of the psychologist appears to significantly limit the purpose of the evaluation.

Submitter : Dr. Edward Peck **Date & Time:** 09/07/2004 06:09:12

Organization : Virginia Psychological Association

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I recommend support for the use of Technicians in the administration and scoring of psychological and neuropsychological tests. In this regard, the American Psychological Association Division 40 (Clinical Neuropsychology), the National Academy Of Neuropsychology and other major professional societies relevant to this issue support the use of technincians, in the administration & scoring of psychological and neuropsychological tests, who are supervised by licensed clinical psychologists.

CMS-1429-P-886

Submitter : Dr. Richard Boada **Date & Time:** 09/07/2004 06:09:33

Organization : The Children's Hospital of Denver

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

It is imperative that this rule change be passed. Psychologists are specifically trained to administer and interpret psychological tests, more so than physicians, whose training and expertise is very different. In fact, if you were to ask any physician what the specific administration procedures are for the Wechsler Adult Intelligence Test-3rd edition, they would not know. They don't perform these procedures, day in and day out, like a neuropsychologist does. As such, it is only logical that psychologists be the ones to supervise the administration of psychometric instruments by technicians, as they would be the only ones in a position to know whether the instruments are being administered in a valid and reliable manner. The psychologist supervisor is also in the position to know whether there are factors that influence a patient's performance and take these into account when interpreting the data. Physicians have limited knowledge of these issues as this is not usually part of their curriculum in medical school or residency training.

The medicare regulation that mandates that a physician has to be the one to directly supervise a psychometrician is outdated. It is based on a hierarchical schema that saw the physician as the sole decision maker when it comes to all aspects of health care practice. This view has been replaced by one that acknowledges that there are different areas of expertise in health care and that practitioners specialize in these different areas in order to provide the best care possible to patients as members of a treatment team. Medicare has already acknowledged that psychologists are independent practitioners. To not allow them to supervise the work that they are ultimately responsible for not only limits this autonomy but places patients in danger. A physician will not have the time or in depth knowledge to ensure the quality of care in psychological testing, which could very well lead to misdiagnoses. The latter is no trivial matter. For example, a neuropsychologist is often asked to evaluate a brain tumor patient to see if there have been neurocognitive changes over time. If there have been, one of the possibilities is that there is recurrence of the tumor, which could necessitate prompt action. If a psychometrician is not administering tests appropriately and the physician is not able to identify and remediate this, the validity of the results would be questionable. As such, a decline in functioning could be missed and treatement delayed with serious medical repercussions.

Having the appropriate practioner, with expertise in psychological testing, supervise technicians is not only the only logical solution, but one that will prevent errors in judgement that can ultimately hurt the american public.

Please pass this regulation change now.

Richard Boada, PhD.
Department of Neurology
The Children's Hospital
Denver, CO 80208

Submitter : Dr. Paul Newman **Date & Time:** 09/07/2004 06:09:42

Organization : Kettering Hospital

Category : Individual

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

As a Psychologist, I am more qualified to supervise the administration and scoring of psychological tests than is a physician who has had no training in this area. This rule change is simply common sense.

CMS-1429-P-888

Submitter : **Date & Time:** 09/07/2004 06:09:06

Organization :

Category : Physician

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

The use of testing assistants is critically important, enhancing the overall care of patients by allowing more individuals to receive help. Assistants overwhelmingly are well trained and, being under the care of licensed psychologists, provide good and ethical service. Reimbursement to the psychologists for their service allows the expanded care of patients.

Submitter : Dr. Larissa Mead-Wescott **Date & Time:** 09/07/2004 06:09:48

Organization : Neuropsychology Service, P.A.

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I am a clinical neuropsychologist. The purpose of this letter is to express my very strong support for the Centers for Medicare and Medicaid Services' proposed rule change (as outlined in CMS-1429-P) that addresses the supervision of psychological and neuropsychological testing by doctoral-level psychologists.

As a clinical neuropsychologist I have completed advanced education and training in the science of brain-behavior relationships. A major part of my practice involves the selection, administration, and interpretation of psychological and neuropsychological tests for the purposes of diagnosis and treatment planning. It is routine for trained psychometrists to carry out the actual administration and scoring of the tests, freeing me to concentrate on matters of interpretation, consultation, and coordination of care - much in the way that a physician would use the data generated by a laboratory technician.

I am at all times responsible for the accuracy, validity and overall quality of all aspects of the psychological and neuropsychological assessment services that non-doctoral personnel provide under my supervision.

The current CMS requirement that neuropsychologists personally administer tests to Medicare and Medicaid patients adversely affects the overall population of Medicare and Medicaid patients because it results in neuropsychologists having less time for interviewing, test interpretation and the coordination of care. The existing requirement reduces the number of patients that each neuropsychologist can serve and results in fewer Medicare and Medicaid recipients being able to access psychological and neuropsychological services. Limited access to necessary care is already a concern in many rural and metropolitan areas; in my area, it is routine for Medicaid and Medicare recipients to have to wait months and even years for an evaluation. For these reasons, I strongly endorse this rule change because it will clearly benefit Medicare and Medicaid patients' by improving their access to psychological and neuropsychological assessment services.

Thank you for the opportunity to comment on this very important matter.

Sincerely,

Larissa Mead-Wescott, Ph.D., ABPP
Neuropsychology Service, P.A.
700 Mt. Hope Ave., Suite 480
Bangor, ME 04401

CMS-1429-P-890

Submitter : Dr. Rex Bierley **Date & Time:** 09/07/2004 06:09:09

Organization : The Permanente Medical Group, Inc.

Category : Hospital

Issue Areas/Comments

Issues 20-29

CARE PLAN OVERSIGHT

Physicians have little or no formal training in the adminisration, scoring and interpretation of psychological and neurpsychological tests. While historically physicains have been granted broad powers across many areas, including this one, supervison of technicans administering psychological instruments, ranging from bedside cognitive status exams to IQ tests, is something that requires specialized training. This type of work is the specality of many clinical psychologsts, and is something that ALL clinical psychologists have had minimal competency training in. Therefore, I strongly recommend that the supervison of technicians who administer these tests be extended to licensed, Ph.D.-level psychologists whose education and experience makes them the most qualified to provide these services to patients. The safety and wellfare of pateints given psychological and neuropsychological tests is best served when they are provided by, or supervised by, those who are most qualified which, in this instance, are clinical psychologists.

Submitter : Dr. David Blair **Date & Time:** 09/07/2004 06:09:41

Organization : Dr. David Blair

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I fully agree with the revisions proposing to allow trained technicians (known as psychometricians), supervised by a licensed doctoral psychologist, to administer and score standard psychological and neuropsychological tests. This is consistent with regulations permitting administration of medical tests by trained, supervised technicians, with the ultimate responsibility for interpretation and diagnosis resting with the licensed clinician, as is appropriate. This will permit the public to obtain the fullest possible range of diagnostic services and to benefit maximally from the professional time and training of the licensed professional, as it does in other areas of public health practice.

Submitter : Dr. Charles Robertson **Date & Time:** 09/07/2004 06:09:08

Organization : Dr. Charles Robertson

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support this rule change.

Submitter : Dr. Hillary Shurtleff **Date & Time:** 09/07/2004 06:09:32

Organization : Children's Hosptial

Category : Other Health Care Provider

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I highly recommend that psychologists be allowed to supervise
psychological and neuropsychological tests performed by ancillary staff (i.e. psychometrists).

CMS-1429-P-894

Submitter : Dr. Aaron Nelson **Date & Time:** 09/07/2004 06:09:48

Organization : Brigham and Women's Hospital

Category : Physician

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly support the planned rule change with the provision for supervision of psychological and neuropsychological testing technicians.

CMS-1429-P-895

Submitter : Dr. Kristin Fiano **Date & Time:** 09/07/2004 06:09:17

Organization : Dr. Kristin Fiano

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I strongly encourage a revision to the policy which would allow for psychologists to supervise psychometrists in the course of psychological testing. Psychologists have the clearest qualification to serve in such a role, and the use of psychometrists is well supported in the field. Psychologists would retain ultimate responsibility for choosing tests, interpreting them, and conveying results. However, the ability to supervise technicians is basic to most practices and should be recognized by Medicare as such.

Submitter : Dr. Edward Jonas **Date & Time:** 09/07/2004 06:09:59

Organization : Dr. Edward Jonas

Category : Other Practitioner

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Psychologists have extensive formal training in neuropsychological and psychological test administration, whereas physicians rarely have any. Psychologists do have the expertise to effectively supervise trained technicians and other ancillary personnel in doing the direct test administration. As with other professional disciplines, Psychologists would retain the professional responsibility for interpretation of results and report writing. I strongly support the rules change regarding outpatient supervision of technicians by psychologists.

Submitter : Dr. Jay Chrostowski **Date & Time:** 09/07/2004 06:09:15

Organization : Aurora Behavioral Health

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support this effort to allow the use of psychological technicians to complete psychological and neuropsychological testing under the supervision of a licensed psychologist. This will allow for more efficient use of time, lower cost, and better patient service.

Submitter : Miss. MAUREEN TORIBIO **Date & Time:** 09/07/2004 06:09:18

Organization : TRIANGLE THERAPEUTICS

Category : Physical Therapist

Issue Areas/Comments

Issues 20-29

THERAPY - INCIDENT TO

SUPPORT THIS BILL

Submitter : Dr. Raymond Singer **Date & Time:** 09/07/2004 06:09:05

Organization : Dr. Raymond Singer

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

I support the right of patients to choose psychological services from a psychologist and psychologists to practice independently of supervision from any other person or entity.

Submitter : Mrs. Lena Zettler Finholt **Date & Time:** 09/07/2004 06:09:34

Organization : Cook Childrens Behavioral Health

Category : Other Health Care Professional

Issue Areas/Comments

Issues 20-29

DIAGNOSTIC PSYCHOLOGICAL TESTS

Please consider allowing master's level clinicians (Licensed Psychological Associates only) to test under the supervision of a licensed psychologist. This is well within the scope of training and practice for LPA's and consistent with the licensing practice of LPA's in Texas